Access for Infants and Mothers Application

SECTION 1

PREGNANT WOMAN INFORMATION: This section gives us basic information about the pregnant woman. If a question does not apply, write "N/A". Submitting a Social Security Number is optional. Answering "YES" to the question(s) about smoking will not affect the enrollment in any way.

Last Name	First Name, M.I.	Social Security Number	Birthdate	
Street Address (P.O. Box not accepted)			Unit/Apt. Number	Phone Number ( )
City	County		State	Zip Code
First day of last menstrual period - **(required)**		Do you smoke? YES/NO	Does anyone in your household smoke? YES/NO	

PRINT BILLING AND MAILING ADDRESS, IF DIFFERENT FROM ABOVE:

Last Name	First Name	
Street Address or P.O. Box		Unit/Apt. Number
City	County	State / Zip Code

Race/Ethnicity: (Optional: Check which best applies)

☐ 1 White	☐ 5b Alaska Native	☐ J Japanese	☐ R Guamanian
☐ 2 Hispanic	☐ 7 Filipino	☐ K Korean	☐ T Laotian
☐ 3 Black/African American	☐ A Amerasian	☐ M Samoan	☐ V Vietnamese
☐ 4 Asian	☐ C Chinese	☐ N Asian Indian	☐ Z Other
☐ 5a Native American Indian	☐ H Cambodian	☐ P Hawaiian	

What language do you speak best? _____ What language do you read best? _____

SECTION 2

1st CHOICE OF HEALTH PLAN: (Applicant must fill out this section)

Instructions: Turn to page 22 in this application to see which AIM health plans are available in your county. Beginning on page 26 you will find a description of each health plan for your review.	
1st Choice of Health Plan:	
Choice of Medical Group/Provider **(if required)**:	Provider Code **(if required)**:

2nd CHOICE OF HEALTH PLAN: (Applicant must fill out this section)

2nd Choice of Health Plan: (if 1st choice is not available)	
Choice of Medical Group/Provider **(if required)**:	Provider Code **(if required)**:

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SECTION 3

FAMILY SIZE, INCOME and INSURANCE INFORMATION: This section will give us information on the pregnant woman's household family size, income, and whether insurance is available for the pregnant woman or the unborn baby.

Part A: Pregnant Woman's Information		
Name	Are you currently employed? YES/NO	
Employer's Name (if employed)	Employer's Phone Number ( ) Ext.	
Employer's Street Address	City State Zip Code	
Source of income (job, social security, pension, etc.):	How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)	How much income is received?
At the time of application, do you have health insurance? YES/NO	If you answer yes to any of the questions, you are REQUIRED to provide the following information: Name of insurance policy or health plan:	
Does the insurance cover your pregnancy? YES/NO	Address:	
If applicable, what is the amount of your deductible or co-payment specifically for maternity services? $ _____	Policy Number:	

Part B: To be completed by the husband, or the father of the unborn child if he and the pregnant woman are living together AND have had at least one other child together. Submitting the social security number is optional.		
Name of father of baby (if living with the pregnant woman)	Birthdate	Social Security Number
Married to the pregnant woman? YES/NO	Are you currently employed? YES/NO	
Employer's Name (if employed)	Employer's Phone Number ( ) Ext.	
Employer's Street Address	City State Zip Code	
Source of income (job, social security, pension, etc.):	How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)	How much income is received?
At the time of application, do you have health insurance? YES/NO	If you answer yes to any of the questions, you are REQUIRED to provide the following information: Name of insurance policy or health plan:	
Does the insurance cover the pregnancy? YES/NO	Address:	
If applicable, what is the amount of your deductible or co-payment specifically for maternity services? $ _____	Policy Number:	

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Part C: See page 12 for more information about income deductions and the required documentation the pregnant woman is required to submit.
List all unmarried children/stepchildren under age 21 of married persons or of unmarried persons who have a child in common, living in the home or away at school who are claimed as tax dependents. Include disabled dependents who live in the home of the pregnant woman and the applicable monthly child day care expense or disabled dependent care expense paid by either the pregnant woman or the father of the baby (if living with the pregnant woman). If there are no expenses write N/A or zero. If more space is needed, write the information on a separate piece of paper and mail it with the application.

Name of Child or Disabled Dependent	Date of Birth	Relationship to the Pregnant Woman	Monthly Amount Paid

Does the pregnant woman pay court-ordered monthly child support or spousal support?	Does the father of the baby, listed in part B, pay court-ordered monthly child support or spousal support?
YES/NO	YES/NO
If yes, how much child support? $_____	If yes, how much child support? $_____
How much spousal support? $_____	How much spousal support? $_____
Documentation Required	**Documentation Required**

See page 11 for more information about income deductions and the required documentation the pregnant woman is required to submit.

Where did you first learn about the AIM Program? (circle one)

1. Doctor's Office
2. Community Clinic
3. Newspaper
4. Internet
5. Hospital
6. Government Office
7. 1-800-BABY-999
8. Employer
9. School/Church
10. Friend/Relative
11. TV/Radio
12. Health Fair/Community Event
13. Insurance Agent
14. Other (specify) _____

SECTION 4

PREGNANT WOMAN'S DECLARATIONS

I declare that:

- I have a reasonable good faith belief that I am not over 30 weeks pregnant as of the application date, and I have enclosed a document certifying that I am pregnant.
- I am a resident of the State of California and have lived here for at least six continuous months prior to the date of signing this application for enrollment.
- I am not and will not be reimbursed by any health care provider or government entity for the payment of my subscriber contribution, with the exception of a California Indian Tribal Government, if applicable.
- I do not have health insurance to cover my pregnancy or have a deductible or co-payment specifically for maternity services of more than $500 through my health insurance policy.
- I am not currently enrolled in no-cost Medi-Cal or Medicare Part A and Medicare Part B at the time of application.
- I give the AIM Program permission to verify my family income, health insurance status, residency and other information presented in the application.
- I will abide by the rules of participation, the utilization review process and the dispute resolution process of any participating health plan in which I am enrolled.
- I have reviewed the benefits offered by the participating health plans.
- I understand and will follow the rules and regulations of the AIM Program.
- I agree to pay the required subscriber contribution even if I do not take full advantage of the coverage or services offered by AIM, and I acknowledge that the AIM Program will take action to collect the full subscriber contribution.

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SECTION 5

AUTHORIZATIONS AND CONDITIONS OF ENROLLMENT

Required by the Confidentiality of Medical Information Act of 1/1/80, Section 56 et. seq. of the California Civil Code for all applicants of 18 years and over: I authorize any insurance company, physician, hospital, clinic or health care provider to provide the Access for Infants and Mothers Administrator any and all records pertaining to any medical history, services or treatment provided to the applicant and for the infant born of the applicant's pregnancy listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as the Administrator requires. A photocopy of this Authorization is as valid as the original.

Privacy Notification

The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Access for Infants and Mothers Program (established by Part 6.3 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal information is for subscriber identification and program administration. Program regulations require every individual to furnish appropriate information for application to the Access for Infants and Mothers Program. Failure to furnish this information may result in non-eligibility determination. The following information on the application is voluntary: social security numbers, race/ethnicity information, and source of referral.

An individual has a right to records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is: Deputy Director, Eligibility, Enrollment and Marketing Division, Managed Risk Medical Insurance Board, P.O. Box 2769, Sacramento, CA 95812-2769. The Board may charge a small fee to cover the cost of duplicating this information.

I understand that this is a State program and my rights and obligations under it will be determined under Part 6.3 of Division 2 of the California Insurance Code and Title 10, Part 5.6 of the California Code of Regulations.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. Page 20 has information about each plan and the arbitration requirements. You may call the plan you choose to find out more.

I, the applicant, certify that I have read and understand the foregoing affidavit and declarations. I also certify that the information I have given on this form is true and correct to the best of my knowledge. I, the applicant, agree to pay the required subscriber contribution and understand that the State will take appropriate actions to collect the full subscriber contributions as outlined in this contract.

X _____ _____

Signature of Applicant — Date

Optional – Authorization to forward AIM application to Medi-Cal.

If my application is ineligible for AIM, I request that this application be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief.

X _____ _____

Signature of Applicant (required) — Date

After you have:

- ☑ filled out the application
- ☑ signed the application
- ☑ collected all necessary income and pregnancy documentation
  - pregnancy certification
  - income verification documents
  - proof of income deductions
  - $50 cashier's check or money order (signed)
- ☑ made your $50 cashier's check or money order (no personal checks or cash) payable to: **Access for Infants and Mothers Program**
- ☑ made photocopies of all documents being submitted for your records — if you choose to do so

Mail your application and other materials to:

Mail Address: **Access for Infants and Mothers Program** **P.O. Box 15559** **Sacramento, CA 95852-0559** ***Please do not fax application***	**Overnight Address:** **Access for Infants and Mothers Program** **625 Coolidge Drive** **Suite 100** **Folsom, CA 95630**

Note: Your completed application must be received by the AIM Program prior to the end of your 30th week of pregnancy in order to be considered for the AIM Program. If you are near your 30th week of pregnancy, you may send your application overnight via Fed-Ex, US Postal Service, etc.

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Pregnancy Certification to be filled out by the applicant:

Pregnant Woman's Last Name	Pregnant Woman's First Name	M.I.
Pregnant Woman's Address		Unit/Apt. Number
City	State	Zip Code

AIM Pregnancy Certification Form

A certification of pregnancy, issued in the United States, must be mailed with your application. The form below can be used to certify pregnancy. You may use a different form as long as it contains the same information as this one and is signed by one of the individuals listed below.

To be eligible for AIM, the pregnant woman must not be more than 30 weeks pregnant as of the date the program receives the completed application. The certification of pregnancy must be signed by a licensed or certified health care professional. Individuals who can certify pregnancy for the AIM Program may include the following:

Physicians (MDs, DOs)
Registered Nurses
Certified Nurse Midwives
Licensed Vocational Nurses
Physician Assistants
Medical Assistants
Staff Person authorized by the Planned Parenthood Organization

Medical office staff cannot certify pregnancy unless the person has a medical license or certification.

To be filled out by the person certifying pregnancy:

I certify that the person listed above is pregnant.

Name of Facility		Date	
Address of Facility		Suite Number	
City		State	Zip Code
Area Code & Telephone Number ( )	Fax Number ( )	Estimated Date of Delivery	
Print Health Care Professional's Last Name **(required)**	Print Health Care Professional's First Name **(required)**		M.I.
Signature of Health Care Professional **(required)**	Medical Title **(required)**		Medical License Number

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